Abstracts from Current Literature

Medicine

Medical Aspects of Gall-bladder Disease. Gow, A. E.: *The Practitioner,* 1938, **140**: 665.

Acute cholecystitis is usually a complication of existing infection. Coliform bacilli are the commonest infecting organisms. In the typhoid group of infections the causal organism is present in the gall-bladder in the majority of cases, yet symptoms, immediate or delayed, are rarely produced. In pneumococcal and *B. influenzæ* infections metastases occur in the gall-bladder. Differential diagnosis must be made from acute pyelitis, an acute appendicitis high up behind the colon, and coronary thrombosis. Pyelitis is differentiated by examination of a catheter specimen. The onset of retrocolic appendicitis is rarely as abrupt as in acute appendicitis, and the pain does not radiate above the diaphragm. At the onset of cardiac infarction the patient is more shocked, dusky and dyspnœic at first than in cholecystitis. The temperature is subnormal at first, and the pulse irregular. Later on a low pyrexia, slight leucocytosis, and a pericardial friction may be observed.

Chronic cholecystitis may or may not follow an acute attack, and is characterized by a dislike of fatty food, an appetite easily satisfied, and flatulence. The condition may be secondary to a "chronic appendix". "Bilious attacks" and sometimes recurrent jaundice occur in this condition.

Focal sepsis is the name given to the form of infection in which toxins are formed in the gall-bladder, with or without symptoms referable to the biliary system. It is very rare that chronic multiple arthritis or allergic states such as asthma or urticaria are due to this cause.

Gall stones are formed as a sequel to cholecystitis except in the case of pigment stones and with the possible exception of the large single cholesterol stone. The use of x-rays in diagnosis is discussed at length. Cholecystectomy should be recommended wherever stones are shown by a cholecystogram, or where colic has been followed in from 24 to 48 hours by obstructive jaundice.

Pancreatitis may complicate cholecystitis. Acute hæmorrhagic pancreatitis may be due to the reflux of bile along Wirsung's duct, activating pancreatic enzymes *in situ*. Chronic pancreatitis may be due to infection tracking up the pancreatic duct from the duodenum or from the bile duct. The treatment of chronic pancreatitis is similar to that of chronic cholecystitis. C. R. BOURNE

Malignant Disease of the Liver. Langmead, F.: *The Practitioner,* 1938, **140**: 683.

Primary malignant growths of the liver are rare, but in the author's series primary carcinomas represented between 3 and 4 per cent of malignant growths in any site. There were in the series three cases of liver-celled carcinoma, and seven of carcinoma of the bile ducts. Cirrhosis provides the only known disposing cause; in this series in all of the cases of liver-celled carcinoma, and in all but two of the cases of carcinoma of the bile ducts, cirrhosis was present.

Secondary carcinomata in the liver are much commoner than primary ones. Their primary source may be in various organs, but liver metastases are rarely found from carcinoma of the lips, tongue and jaws. Of secondary sarcomata, melanotic sarcoma, lymphosarcoma, and neuroblastoma of the right suprarenal capsule are noteworthy.

Diagnosis is made from the observation of enlargement and nodulation of the liver, pain, jaundice, ascites, œdema of legs, and cachexia. If umbilication of a nodule is found one can conclude that the growth is secondary. Greater enlargement of the left lobe also favours secondary growth. Stony hardness is diagnostic of carcinoma. The enlarged liver of carcinoma is distinguished from that of cirrhosis by its nodulation; the relatively small nodules of the cirrhotic liver can not usually be felt through the abdominal wall. When carcinoma is added to cirrhosis the early stages are unrecognizable, but wasting, anæmia, pain and tenderness soon show the presence of malignancy. Syphilis of the liver may resemble carcinoma, but there is little or no jaundice, no pain, and no deterioration in the general condition. Further, the Wassermann reaction helps where doubt still remains. Hydatid disease is usually characterized by a single, resilient swelling, and is accompanied by eosinophilia. Aspiration, complement-fixation or precipitin tests, and the intradermal reaction will settle the diagnosis.

In primary carcinoma of the liver the duration is usually only a few months; in cases of secondary growth the duration depends on the primary source, and may be as much as a year. Treatment can only be palliative. The patient should be relieved from pain. Purgatives acting on the large bowel are preferable. Paracentesis in cases of ascites may be warranted. Operation is almost never justified. C. R. BOURNE

Surgery

Principles of Surgical Practice. The Treatment of Fresh Wounds. Reid, M. R. and Stevenson, J.: *Surg., Gyn. & Obst.,* 1938, **66**: 313.

The authors record certain observations which they deem essential to the proper understanding of the problem. Arrest of hæmorrhage, the presence of devitalized cells and of bacteria usually found in the depths of all traumatic wounds, good circulation, the remarkable recuperative power of all living cells, the release of stimulatory substances from the edges of the wound, the value of proper temperature for healing, and rest, all have their rôle in healing

and must be considered. The aseptic practice is usually not adequately adhered to; the wound is usually found to be free from bacterial infection until 6 to 8 hours after injury even though it be grossly contaminated, and precautions to prevent bacterial entry should include masking of everyone present. Ligation should be specific in area and not "mass" ligation. Washing of the wound with soap and water and irrigation with normal saline will remove most of the contamination; débridement should be carefully done. In other words, one should attempt to leave the wound in such a condition that the fixed-tissue cells can accomplish the work of repair without necessitating the influx of wandering-cells to remove débris, blood-clot, excessive suture material, foreign-bodies, bacteria, tissue-cells destroyed by excessive "antiseptics", and excess of antiseptic chemicals. The position of the part, particularly in œdema, is important. Maintenance of fluid balance and of proper blood supply are concomittant with the administration of nourishment to the injured. *In vitro* extracts of embryonic tissue, such as liver, hasten cell growth. Vitamin C in scorbutics, correct pH values have been utilized and may soon have ready clinical application. Rest of the injured, rest of the injured part have their counterpart in rest for the granulation tissue in passive and active application. Finally, the one most often found unmasked in the operative field is the patient.

FRANK DORRANCE

Bilateral Non-tuberculous Ilio-psoas Abscess. Ortmayer, M.: *Surg., Gyn. & Obst.*, 1938, **66**: 778.

Ilio-psoas abscess developed in a girl of 8 years after lobar pneumonia. The pneumonia was present in both lower lobes, with later either unresolved pneumonia or empyema in the left base. There was marked right upper quadrant muscular resistance and tenderness within 3 days of the onset of the illness. Diarrhœa was an early and persistent finding. Irregular fever and polymorphonuclear leucocytosis persisted. Late in the 2nd month occasional vague, shifting, abdominal cramps gradually localized, with some swelling in both lower quadrants. The swelling increased in size and the pain lessened until at the end of 3 months extraperitoneal incision above the inguinal ligaments drained two large ilio-psoas abscesses with prompt relief. Direct smears revealed a capsulated Gram-positive diplococcus and a Gram-negative bacillus. It is probable pus from a left posterior pleural sinus infection ruptured into the posterior mediastinum, passing thence along the aorta under the median arcuate ligament to the level of the 3rd lumbar vertebra, and then becoming bilateral on the surface of each psoas muscle.

Comment is made on several previous cases, particularly those of Foot and F. J. Tees, in the discussion of the anatomical paths which ilio-psoas abscess may follow. The pus does pass distally anterior, in or posterior to the psoas or quadratus lumborum sheaths, and it perforates the diaphragm anteriorly and passes anterior to and over the liver.

FRANK DORRANCE

Regional Ileitis. A Review of the Literature and a Case Report. Lick, M.: *Surg., Gyn. & Obst.*, 1938, **66**: 340.

The pathology of this condition is based upon the monograph of Crohn *et al.* in 1932. The condition had been reported by several writers prior to this time, usually under the name of infective granuloma. The literature of the past 100 years contains several reports under diferent names. The author is not able to give more light on the etiological factors than previous writers. Regional ileitis is a progressive entity, progressing from the signs of acute intra-abdominal disease with peritoneal irritation to those of ulcerative enteritis, with later partial or complete stenosis and persistent fistulas. The x-ray findings are in keeping with these stages, referred particularly to the last loop of small bowel. The symptoms in order of frequency are abdominal pain 72 per cent, loss of weight 60, palpable mass 58, diarrhœa 52, anæmia 42, fever 38, fistula 36, vomiting 28. Some believe the early manifestation is small ulcers along the mesenteric border of the terminal ileum, although such observations have seldom been made. The ileum is usually found to be greatly enlarged, soggy, purplish, blotchy red and œdematous. It is compared to a heavy-bodied snake. The lymphœdema is the most marked feature. The author regards medical measures as entirely unsuccessful, although he admits that some cases recover spontaneously. Review of the surgical treatment favours multiple stage resection of the affected part. He does not give an answer to the problem encountered when the distal two or three feet of the ileum are found as congested as the appendix vermiformis.

FRANK DORRANCE

Obstetrics and Gynæcology

The Relationship of Fetal Birth Injuries to Obstetric Difficulties. Scott, W. A.: *Am. J. Obst. & Gyn.*, 1938, **35**: 471.

A statistical consideration of birth injuries following any type of delivery is of little value unless accompanied by a study of all the clinical facts in each case. Some intracranial hæmorrhage occurs frequently in so-called normal labours and in many cases causes no symptoms. Some babies having clinical evidence of such injury recover and evidence no permanent damage. The incidence of severe injury increases with the length of labour and also with attempts to shorten it by operative delivery from below. The danger to the mother from Cæsarean section must not be forgotten when

thinking of the danger to the child from vaginal delivery. The increasing number of elderly primiparæ and the desire for short and painless labours are factors in infant mortality at the present time. Many serious injuries to the child are the results of either unwise or unskilful operative deliveries. In many cases there is inevitable danger of serious injury to the child in a properly conducted labour. The conscientious obstetrician can only do that which he thinks is in the best interests of both mother and child. ROSS MITCHELL

Early Diagnosis of Cancer of the Body of the Uterus. Pratt, J. D.: *Am. J. Obst. & Gyn.*, 1938, **35**: 395.

Bleeding is the most common symptom of adenocarcinoma of the body of the uterus. Three case reports illustrate the importance of irregular pre-menstrual bleeding, the significance of post-menopausal microscopic bleeding and the association of adenocarcinoma and hyperplasia. A chart is presented which stimulates the interest of the patient in bleeding, provides a graphic record, and aids in the interpretation of pre-menstrual bleeding. Examination of a single fragment of tissue is inadequate. Sections from all the curetted material should be studied. Early diagnosis of adenocarcinoma of the body of the uterus depends upon the education of the laity to observe and report all irregularities of pre-menopausal bleeding and all post-menopausal bleeding. ROSS MITCHELL

Investigations into the Transit of Ova in Man. Westman, A.: *Brit. J. Obst. & Gyn.*, 1937, **44**: 821.

The author refers to the histological finding of smooth muscle in the ligamentum ovarii proprium, also in the ligamentum suspensorium ovarii. These fibres run parallel with the blood vessels. These smooth muscle bundles contract intermittently during ovulation. There are no closed bursæ ovarii in man. The ovum gets into the tube direct. There is also a compensatory sucking movement toward the ostium abdominale, as proved experimentally. The rhythmical contraction waves in the ligaments are hormonically controlled, being more pronounced with follicular maturation. The author experiments through an abdominal window. A meso-tubarium inferius and meso-tubarium superius are clearly seen. During ovulation the entire tube is drawn rhythmically down to the uterus, the two tubal parts approach one another, the meso-tubarium superius becomes taut, allowing the attached fimbriæ to spread out. The ovary was seen to shift its position cranially and caudally allowing various parts of ovarian surface, to contact the fimbriæ of the tube during ovulation. Contractions every 7 to 20 seconds are seen, while during non-œstral periods the contractions are weak and slow. During non-œstral periods the tube and ovary lie free, separated, but during ovulation the tube forms a bow-shaped arrangement about the ovary. On ovulation, therefore, the infundibulum is thus brought up and down across the ovary, which itself turns to and fro on a longitudinal axis, causing different parts of the ovarian surface to face the ostium abdominale. Altered pressure conditions within the follicle and circulatory changes in the raised portion of the mature follicle favour rupture at this point. P. J. KEARNS

The Effect of Progesterone on the Metaplasia of the Uterine Epithelium of Rats injected with Œstrogens. Korenchevsky, V.: *Brit. J. Obst. & Gyn.*, 1938, **45**: 22.

The author made a careful histological study of epithelial changes in the uterine mucosa after repeated treatments with progesterone and œstrogenic substances. The metaplasias produced by his experiments point toward a possible cause of cancer, in that metaplasia often precedes cancerous changes. Experiments were performed on 27 rats injected with œstrone, or œstradiol alone or in combination with progesterone. After three or four weeks' daily injection the author could show with heavy dosage pronounced multicentric metaplasia of the uterine epithelium. Small doses did not produce it. Progesterone inhibits this metaplasia from progressing. The possible significance of these facts in relation to the treatment of women with sex hormones, and in the pathogenesis of cancer, is discussed. P. J. KEARNS

Ophthalmology

Allergic Reaction of Trachoma. Danilewshy, I. A. and Kaminsky, P. G.: *Ann. d'Ocul.*, 1938, **175**: 245.

It is natural to expect that a chronic infectious disease like trachoma might set up different changes in the body. Straub pointed out the differences in the sensitiveness to trachoma in infants and adults. Among the Russian writers Warchawsky drew attention to the fact that a relative immunity to trachoma develops little by little with age, and notes the importance of this immunity. Ostrounow doubts the development of any such immunity in adults, but draws attention to the great susceptibility of infants to trachoma, and to the fact that in children the condition develops with great intensity and reacts very poorly to treatment. Besides clinical observations, research has been made on the particular qualities of blood and serum of trachomatous patients, even after they have developed immunity. Many have tried these tests with the aid of vaccine and the majority conclude that the reaction has no diagnostic significance and is not specific. The results too obtained were quite divergent.

Unfortunately the virus of trachoma and its allergic properties being still unknown, the

authors employed the technique approved in the clinic of Glaubersohn. The preparation of the antigen is given in detail and the reactions obtained in trachomatous and control patients are shown by three charts. Bibliography.

S. HANFORD MCKEE

The Treatment of Trachoma by Local Auto-serotherapy. Jourdan, H.: *Ann. d'Ocul.*, 1938, **175**: 254.

Trachoma is one of the ocular diseases for which a great many therapeutic aids, both physical and medicinal, have been tried with more or less indifferent results. Also certain of these treatments are exceedingly painful. On this account the author has thought it of interest to publish the results obtained by local auto-serotherapy. The technique for the preparation of the serum is simple. It consists in the removal of a certain quantity of blood by aseptic venous puncture, which, after centrifugalization and fractional sterilization, is put in sealed ampoules. The serum is then ready to be injected into the tarsal conjunctiva. The author usually injects 0.5 c.c. (very rarely more) after an analgesic either once or twice a week. The injections are well taken. Sometimes slight pain is complained of; sometimes they are followed by a slight swelling which lasts never more than two or three days. In all cases there has been a rapid diminution in symptoms and improvement in the conjunctival and corneal irritation. Pannus rapidly disappeared, photophobia and tearing were much improved. The author has also noted a more or less rapid diminution in the granulations themselves, though he has had very few observations in which he has been able to follow long enough to judge of the persistence of the cure.

Eight observations are given by the author showing the progress of different patients. Bibliography.

S. HANFORD MCKEE

Urology

On Malignant Disease of the Testicle, with Special Reference to Neoplasms of the Undescended Organ. Gordon-Taylor, G. and Till, A. S.: *Brit. J. Urol.*, 1938, **10**: 1.

The vexed problem of nomenclature of testicular neoplasms is not reopened, but the simple classification into seminoma and teratoma is used since the difference in prognosis as well as in gross pathology is well demarcated. Teratomata may occur at any age, with the greatest incidence at 28 years, and seminomata also attack younger patients than most cancers, averaging 40 years. Bilateral testicular tumours, reported cases in each of twins or in polyorchidism are very rare. A history of injury was present in 20 per cent of the present cases, but it is inferred that trauma and infection may greatly accelerate the growth of the tumour.

Clinically, the loss of sensation is early and complete. The hurricane type of case is most often seen post-operatively, but acute pre-operative types are noted in young patients and those of intemperate habits. Slowly-growing cases may give a history of tumour for two to even ten years before advice is sought. Occasionally the primary growth gives no symptoms and metastases in the lungs, neck, axilla or sexual precocity, breast hypertrophy, or pain in the back may dominate the picture, the gonad remaining small. The quantitative Ascheim-Zondek reaction is useful in distinguishing teratoma from other swellings and also in judging the radiosensitivity of the tumour. There is no cause for remorse in removing a syphilitic testicle on mistaken diagnosis, but spontaneous hæmorrhage and tuberculosis or spermatic thromboangiitis are sometimes difficult differential diagnoses to make.

Of 50 cases 15 occurred in the undescended testis and the authors feel that the retained organ is much more liable to malignancy, and when it occurs the prognosis is very gloomy. Cases are cited in which malignancy occurred after operation for non-descent, and after operation for return of an undescended testicle into the abdomen.

Primary carcinoma of the epididymis is extremely rare.

The prognosis in teratomata is being improved by the addition of prophylactic irradiation to orchidectomy, but remains very poor. On the whole, seminomata are quite radiosensitive. The radical extended operation has been losing favour since the keener appreciation of the lymphatic connections of the testicle. Now simple orchidectomy combined with deep x-ray therapy is the method of choice.

BURNS PLEWES

Neurology and Psychiatry

Normal Ventriculograms in Tumours of the Cerebral Hemispheres. Pennybacker, J. and Meadows, S. P.: *The Lancet*, 1938, **1**: 186.

At necropsy in all hemisphere tumours there is some displacement of the septum pellucidum and some disturbance of the symmetry of the ventricles. It is generally considered that ventriculograms which show no such displacement or asymmetry in the axial views indicate that no tumour of the hemisphere could be present. Four cases of cerebral tumour are reported in which the ventriculograms showed no lateral displacement of the ventricular system, or any other abnormality in the axial projections, at a time when the tumours had already produced well-marked physical signs. These tumours were all gliomata, 2 of them astrocytomata, and 2 spongioblastomata. Histologically, they did not differ from other gliomata which do produce ventricular deformities. Two were chiefly parietal, one fronto-temporal, and one frontal in location. In each case the clinical picture was that of a progres-

sive neoplastic lesion. A small tumour growing from the meninges displacing the brain before it is more apt to produce ventricular deformity than an invasive tumour of the same size growing in the substance of the hemisphere, and infiltrating rather than displacing the brain. The absence of lateral displacement of the ventricular system with hemisphere gliomata does not appear to be related to any particular location of the tumour. A small infiltrating glioma in an eloquent site may give rise to symptoms and signs before it produces ventricular deformity, and is evidently more likely to behave in this manner than a meningioma of the same size in the same situation. But it is also evident that large diffuse gliomata may occasionally run their whole course, even to the death of their hosts, without producing any gross ventricular deformity. FRANK TURNBULL

Pathology and Experimental Medicine

The Chemical Composition of Voluntary Muscle in Muscle Disease: A Comparison of Progressive Muscular Dystrophy with other Diseases together with a Study of the Effects of Glycine and Creatine Therapy. Reinhold, J. G. and Kingsley, G. R.: *J. Clin. Investigation,* 1938, **17**: 377.

These authors found that the chemical composition of muscle in progressive muscular dystrophy was altered more extensively than in diseases with secondary atrophy of the muscles. Changes comparable with those found in progressive muscular dystrophy were observed in diffuse myositis and in amyotrophic lateral sclerosis. In progressive muscular dystrophy concentrations of creatine and other substances extractable by dilute acid were diminished. Phosphocreatine and adenosine triphosphate constituted a smaller proportion, and soluble ester phosphorus and inorganic phosphorus a larger proportion of the total acid-soluble phosphorus, compared with control specimens of muscle normal in appearance.

The authors conclude that analysis of muscle can be used to supplement clinical and histological examination in diagnosis and in measurement of the deterioration of muscle.

JOHN NICHOLLS

The Renal Factor in Arterial Hypertension with Coarctation of the Aorta. Rytand, D. A.: *J. Clin. Investigation,* 1938, **17**: 391.

A consideration of hydrodynamics indicates that the arterial hypertension which is present in the upper part of the body in coarctation of the aorta cannot be explained on the purely mechanical grounds of obstruction to the blood flow. In this condition there is an increased resistance in the smaller vessels which receive blood from the aorta proximal to the stenosis of its isthmus. The cause of this localized increased resistance is the same as that of the generalized increased resistance in a dog in which the renal artery has been partially occluded, that is, interference with the blood supply to the kidneys. This conclusion is supported by the production of hypertension in rats by partial occlusion of the aorta proximal to one or both arteries. With partial occlusion of the aorta between the renal arteries hypertension occurs only when living renal tissue is present distal to the occlusion. After simultaneous distal nephrectomy hypertension never occurs, even though there exists the same degree of mechanical obstruction to the blood flow offered by the stenosis and presence of a collateral bed. JOHN NICHOLLS

The late Effects of Bilateral Carotid Sinus Denervation in Man. Report of two Cases, with Studies of the Vascular Reflexes. Capps, R. B. and de Takats, G.: *J. Clin. Investigation,* 1938, **17**: 385.

Two cases are reported in which a bilateral carotid sinus denervation and a bilateral cervicodorsal sympathectomy were performed. The vascular reflexes of these patients were studied 17 and 8½ months after the operations, respectively. There was no elevation of the blood-pressure or of the pulse-rate at this time as a result of operation. There was no increased lability of the blood-pressure and the pulse, as shown by an exercise tolerance test. A marked postural hypotension was found in both patients. The authors feel that these findings are significant. They point out the possibility that a similar mechanism, namely, loss of sensitivity of the carotid sinuses to normal physiological stimuli, may account for the findings in certain cases of idiopathic postural hypotension.

JOHN NICHOLLS

Cyanosis without Sulph- or Methæmoglobinæmia in Patients receiving Sulphanilamide Treatment. Chesley, L. C.: *J. Clin. Investigation,* 1938, **17**: 445.

Cyanosis has been frequently observed in patients under treatment with sulphanilamide. This cyanosis is almost universally attributed to sulphæmoglobinæmia or methæmoglobinæmia though few observers have actually identified these substances in cyanotic patients.

Chesley ruled out the presence of these substances in 8 patients showing cyanosis after receiving sulphanilamide. The theoretical carbon-monoxide capacities calculated from the blood irons and the measured CO capacities checked closely. Therefore, all the hæmoglobin was present in an active form. The author, on the basis of his work, was unable to offer any explanation of the cyanosis in these cases.

JOHN NICHOLLS

Hygiene and Public Health

Progress in the Control of Diabetes. *Stat. Bull., Metropol. Life Insur. Co.*, 1938, 19: 1.

When vital statistics are studied by age groups it is apparent that considerable reduction in the death rate of younger persons from diabetes has occurred since the introduction of insulin. In the experience of the Industrial Department of the Metropolitan Life Insurance Company, among males in the age groups 1 to 24, 25 to 34 and 35 to 44 there has been a definite and marked decline in the death rate since 1923. This decline has occurred among women but not quite so dramatically as among men.

In the age group 45 to 54 for both men and women the death rate has remained almost stationary for 25 years. In the older age groups the death rate has increased quite markedly. It is quite probable, however, that this recorded increase in deaths in the older age-groups is more apparent than real. The great interest in diabetes which was awakened with the discovery of insulin has undoubtedly resulted in more frequent diagnoses. FRANK G. PEDLEY

Silicosis Hazard in State Foundries Found in Mild Degree. *Indust. Bull., N.Y. Dept. of Labor*, 1938, 17: 214.

A survey of the foundry industry in New York State, conducted by the Division of Industrial Hygiene of the State Department of Labour, involved the examination (with x-ray) of 4,754 workers in 80 plants. These plants covered iron, steel, non-ferrous and combined foundries.

Of the men examined some were clerical and outside workers with presumably little exposure; 4.5 per cent of foundry workers, 1.1 per cent of pattern makers, and 1.7 per cent of clerical and supervisory workers showed evidence of fibrosis of the lungs. The higher incidence among the foundry workers is undoubtedly a reflection of an occupational dust exposure.

Definite silicosis occurred in 114 cases, 110 of which were among the 4,066 foundry workers, yielding a rate of 2.7 per cent. This percentage probably does not reflect the true picture because many of the workers had been employed for less than 5 years. Among those employed over 40 years the incidence was 9 per cent. Of the 110 cases among foundry workers 88 were first stage, 16 second stage, and 6 third stage.

FRANK G. PEDLEY

OPTIC NEURITIS.—Clay and Baird describe 7 cases of unclassified optic neuritis with no general symptoms for from 5 to 22 years, but with soreness and pain on movement of the eyes, usually following malaise, slight colds, or sore throats. Post-neuritic atrophy occurred early, and if vision did not improve in 6 weeks the prognosis was grave. There was no focus of infection or familial disease, and the Wassermann reaction was negative. The authors contend these cases fall into a new category—acute infectious optic neuritis caused by a virus with a predilection for the optic nerve.—*Arch. Ophthal.*, Nov. 1937, p. 777. Abs. in *Brit. M. J.*

Obituaries

Dr. George Elliot Cook, of Toronto, died on July 1, 1938. Born in Morrisburg, Ont., in 1871, Dr. Cook was a son of the late Simon Cook, M.P. He acquired his public and high school education in Morrisburg, graduating in medicine from the University of Toronto in 1896 and taking post-graduate courses in the University of Edinburgh. His brief practice in Chicago was followed by his leaving the profession and becoming vice-president of a lumber firm in Toronto. When he retired from that he resided on his farm at Rice Lake, north of Cobourg.

Dr. Charles Rea Dickson, of Toronto, died recently. He was in his eightieth year and was born at Kingston, Ont. He was the son of the late Dr. John Robinson Dickson, founder of the Medical Department of Queen's University, and Anne Benson Dickson, both of Belfast, Ireland. A graduate in arts and medicine (1880), Queen's University, he carried on post-graduate work in New York Hospital and Bellevue Hospital, New York. He also held the M.D. of the University of New York (1881). He was elected President of the American Electro-Therapeutic Association on three different occasions. He was at one time head of the x-ray department of the Toronto General Hospital. He lost his sight more than twenty years ago from the use of the ultra-violet ray before its power was understood.

One of the first of the medical fraternity to introduce electro-therapy in Toronto, he was instrumental in establishing departments for electro-therapy in the Toronto General, the Hospital for Sick Children, and St. Michael's Hospitals.

Associated with the late Dr. George S. Ryerson, he assisted in the establishment of the Order of St. John of Jerusalem in Canada. When serving as General Secretary for Canada with the Canadian Red Cross, he was the recipient of a personal letter from Queen Alexandra commending his work.

Dr. Dickson was the author of many treatises on electricity, goitre and first aid. One of the charter members and member of the first council and executive committee of the Canadian National Institute for the Blind, he was the first President and General Secretary. At the time of his death he held the office of an Honorary Vice-president of the Institute. He received the King George VI Coronation Medal.

Surviving are one brother, Edwin Hamilton Dickson, of Waco, Texas, now in South Carolina; and one sister, Mrs. Bruce, widow of Rev. Dr. George Bruce, founder of St. Andrew's College, Toronto.

Dr. John Esler died at his home at Cereal, Alberta, early in July, 1938. Following his graduation from the University of Toronto in 1902 he registered in Dakota, where he practised for nearly twenty years. Then he came to Alberta and made his home at Cereal, where he practised until the time of his death. He built his own private hospital, which he kept open even during the long period of drouth. He was a remarkable man in numerous ways and many who have been helped or cured, when they had no means to pay him will long remember his kindly assistance.

Dr. Francis Wesley Forge, of Toronto, died recently. He was born in Megantic, Que., and brought up in Moose Jaw. Upon graduation from the University of Toronto (1919) he practised at Wiarton, Ont., and after his marriage to Miss Phoebe Elizabeth Cobourn, moved to Kentucky, where he was engaged in public health work. He had practised in Toronto since 1932. Dr. Forge served overseas in the "Sportsmen's Battalion", leaving the University of Toronto to fight in the ranks.

Dr. John Thomson Green, of Hamilton, Ont., died on July 13, 1938. He was born in London, Ont., in